PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G094	A. BUILDING _____ B. WING _____	09/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 05	6934 9TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from September 25, 2007 through September 28, 2007. The survey was initiated using the fundamental survey process. A sample of three clients was selected from a resident population of six men with various disabilities. On September 27, 2007, at 6:18 PM, the survey was extended in the Condition of Client Protections, following deficiencies identified during the review of incident reports and investigations and review of the facility's incident management policies and procedures. The findings of the survey were based on observations and staff interviews in the home and at two day programs, interviews with three clients and one client's court-appointed guardian, as well as a review of client and administrative records, including incident reports. The determination was made that the facility was not in compliance with the Condition of Participation in Client Protections.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews, and the review of records, the facility's governing body provided general operating direction except in the following areas: The findings include: 1. Cross-refer to W124. The governing body	W 104	1. See response to W124	11/2/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Marsha A. Thompson — Director of Disability Services — 10/25/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 failed to establish and implement a system to ensure that court-appointed guardians were kept informed of clients' medical conditions and recommended treatments, and to ensure that the guardians' participation in the decision-making process was encouraged and aggressively sought by the facility. 2. Cross-refer to W149. The governing body failed to establish and/or implement policies that ensured the health and safety of its clients.	W 104	2. See response to W149	11/2/07
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to develop and implement effective policies and procedures to ensure the implementation of its incident management system [See W149]; failed to ensure that all allegations of neglect or abuse, as well as injuries of unknown source, were reported and investigated thoroughly [See W153 and 154]; and failed to ensure that investigations were reported to the administrator or designated representative within five working days of the incident [See W156]. The effects of these systemic practices results in the failure of the facility to protect its clients from harm and to ensure their general safety and well being.	W 122	The Director of Disability Services (DoDS) will revise the agency policy to ensure it encompasses all requirements of both the Departments of Health and Disability Services. The DoDS will provide a re-training to the QMRP, Residential Director (RD) and home staff. The DoDS will also review the internal communication and investigative process with the Incident Management Coordinator (IMC) to ensure that incidents and investigations are reported to the DoDS within 5 working days of the incident.	11/2/07
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients.	W 124		

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W 124	Continued From page 2 Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to document actions taken to ensure the right of each client and/or legal guardian to be informed of the attendant risks of treatment and the right to refuse treatment, for three of the three clients in the sample. (Clients #1, #2 and #3) The findings include: During the Entrance Conference on September 25, 2007, the Resident Director (RD) indicated that he had begun working with these clients in July 2007. At 2:41 PM, he thought Client #1's brother was his legal guardian, Client #2's brother had "limited involvement" and Client #3's sister was his legal guardian. However, the RD advised surveyors to confirm this in the clients' records. The RD agreed to provide a list of names and telephone numbers of clients' legal guardians and involved family members. 1. Interview with the Residential Director on September 25, 2007 at 2:33 PM revealed that Client #1 was prescribed psychotropic medications and utilized a Behavior Support Plan (BSP) to address maladaptive behaviors. Observation of the evening medication administration on September 25, 2007, beginning at 5:30 PM, confirmed the RD' s statement by	W 124	1. The QMRP will prepare written information on the risks and benefits of proposed treatments. The QMRP will schedule a meeting to explain the treatments and get signed consent from family member. The QMRP will provide written information and explanations of treatment for signed consent at least annually and more frequently if current treatments need modification or if new treatments are to be introduced.	11/2/07

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W 124	Continued From page 3 revealing Client #1 received Buspar, Risperdal and other medications. Interview with the Qualified Mental Retardation Professional (QMRP) on September 25, 2007, at 2:40 PM, revealed that Client #1 did not have the capacity to give informed consent for the use of his medications, habilitation services, and finances. The statement was verified through the review of Client #1's psychological assessment (dated October 31, 2006) on September 27, 2007. According to the assessment, Client #1 "does not evidence the capacity to make independent decisions on his behalf regarding his habilitation planning, treatment, placement, financial and medical matters." Further interview with the QMRP on September 27, 2007, at 4:01 PM, revealed that the client had family involvement (brother) but did not have a legal guardian. Interview with the QMRP and review of Client #1's records on September 27, 2007 and September 28, 2007 failed to provide evidence that informed consent was obtained for the use of the client's medications. At the time of the survey, the facility failed to provide evidence that Client #1's treatment needs, including the benefits and potential side effects associated with his medications, and the right to refuse treatment, had been fully explained to him and his brother. 2. Interviews and record review revealed that the facility had not established and implemented a system to inform Client #2's court-appointed guardian of changes in his medical condition and/or recommended treatments, or otherwise ensured the guardian's participation in the decision-making process, as evidenced by the	W 124		

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W 124	Continued From page 4 following: a. On September 26, 2007, interview with the QMRP revealed that she did not think any of the six clients had court-appointed guardians. The list of guardians and involved family members that was presented to surveyors on September 26, 2007 (as per the request made during the Entrance Conference on the day before) did not indicate that Client #2 had a guardian. It was later determined, however, that he had a court-appointed guardian. b. On September 28, 2007, beginning at 9:52 AM, review of Client #2's Individual Support Plan (ISP), dated April 30, 2007, revealed an address and phone number for a legal guardian. Court documents indicated that the individual was assigned "permanent legal guardianship" on May 26, 2004. His Psychological Assessment, dated April 4, 2007, indicated "... low moderate range of mental retardation cognitively and cannot make independent decisions..." The ISP (written in the first-person) stated "I need someone to help me make a decision on where to live,, how to spend my money... whether I need medicines or not, decide what actions to take in order for me to be healthy and safe... someone to protect me from being exploited..." However, further review of the ISP revealed that: (1) The last page of the ISP document had a space designated for the guardian's signature of approval. That space, however, was left blank. (2) The guardian's signature was not indicated on the April 30, 2007 ISP meeting attendance sheet.	W 124	2.a. The QMRP will contact families and case managers to ensure that a current, updated contact list is available in each person's record and on the health passport. 2.b.1. The QMRP will forward a copy of the latest ISP to the person's guardian for review and approval. 2.b.2. See response to #1 above.	11/2/07 11/2/07 11/2/07

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W 124	Continued From page 5 (3) On October 1, 2007, at 10:28 AM, the guardian returned a telephone message left during survey. She stated that she had not been notified of an April 2007 team meeting. [Note: During the telephone interview, she indicated that the most recent visit to the facility was achieved prior to a February 27, 2007 court hearing.] c. On September 26, 2007, beginning at 9:45 AM, review of Client #2's incident reports revealed that on March 28, 2007, the client told staff that a bruise observed on his lower back was due to a fall. And on May 11, 2007, the client sustained an abrasion to the top of his head after he reportedly hit his head while exiting the facility's van. (1) Neither of the two incident reports indicated that his guardian was informed of the injuries, in accordance with the facility's policies and procedures. (2) On October 1, 2007, the guardian confirmed by telephone that she was previously unaware that the client had sustained the two aforementioned injuries. d. On September 28, 2007, at approximately 5:15 PM, review of Client #2's Nursing notes revealed that he was treated with the antibiotic Cipro 500 mg for 10 days. Further review of the record failed to indicate the reason for the treatment; however, interview with the designated nurse revealed that it was prescribed by the primary care physician (PCP) after the client complained of urinary frequency. Telephone interview with the client's guardian on October 1, 2007 revealed that she was previously unaware of the client's treatment with Cipro.	W 124	2.b.3. The QRP will ensure that all families and guardians are made aware of and invited to ISP meetings by letter not less than two weeks prior to the meeting. 2.c.1. The DoDS will re-train the QMRP, IMC, and RD to ensure they notify everyone in accordance with facility policy. 2.c.2. See response to #1 above. 2.d. See response to #1 above.	11/2/07 11/2/07 11/2/07 11/2/07

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W 124	Continued From page 6 e. On September 28, 2007, at approximately 5:20 PM, review of Client #2's physician's orders revealed that on November 7, 2006, the PCP had prescribed Ativan 2 mg for sedation 1 hour before an MRI of the brain. (1) Further review of the record failed to show evidence that the guardian had been informed of the recommended procedure or use of sedation. (2) There was no written consent form for the use of Ativan sedation observed in the client's chart. (3) Telephone interview with the client's guardian on October 1, 2007 revealed that she was previously unaware that he had been sedated with Ativan or that he had gone through the MRI procedure. 3. Interview with the Resident Director on September 25, 2007, at 2:33 PM, revealed that Client #3 was prescribed psychotropic medications and utilized a BSP to address maladaptive behaviors. Observation of the evening medication administration on September 26, 2007 beginning at 5:50 PM confirmed the RD's statement by revealing Client #3 received Zyprexa 5 mg and other medications. Interview with the QMRP on September 25, 2007, at 2:40 PM, revealed that Client #3 did not have the capacity to give informed consent for the use of his medications, habilitation services, and finances. The statement was verified through the review of Client #3's available psychological assessment (dated November 16, 2005) on September 28, 2007. According to the	W 124	2.e.1. See response to #1 above. 2.e.2. See response to #1 above. 2.e.3. See response to #1 above. 3. See response to #1 above.	11/2/07 11/2/07 11/2/07 11/2/07

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W 124	Continued From page 7 assessment, Client #3 "cannot make independent decisions on his behalf regarding his habilitation planning, placement, financial, and medical matters." Further interview with the QMRP on September 27, 2007, at 4:01 PM, revealed that the client had family involvement (sister) but did not have a legal guardian. Continued interview with the QMRP and review of Client #3's records on September 28, 2007 failed to provide evidence that informed consent was obtained for the use of the client's medications. At the time of the survey, the facility failed to provide evidence that Client #3's treatment needs, including the benefits and potential side effects associated with his medications, and the right to refuse treatment, had been fully explained to him and to his sister.	W 124		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure privacy during personal care, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include: On September 2, 2007, at approximately 6:55 PM, observation of the upstairs bathroom revealed no blinds or curtains in the window. An apartment building located a few properties over, in the back, was clearly visible when standing in	W 130	The RD will ensure the window in the bathroom is covered by a curtain and/or a shade.	11/2/07

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W 130	Continued From page 8 the center of the room, or in front of the toilet. Presumably, persons in the apartment building could see clients taking care of their personal needs, especially when the lights were turned on after dark. Clients used the upstairs bathroom for showering. At the time, the Resident Director acknowledged that the window was without a cover, to ensure the clients' privacy.	W 130		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies to ensure the health and safety of four of the six clients residing in the facility. (Clients #1, #2, #4 and #6) The findings include: 1. The facility failed to document the notification of the State agency of significant incidents, in accordance with their incident management policy, as follows: Cross-refer to W153. Review of the facility's incident reports, investigations and client records on September 25-27, 2007 revealed evidence of four incidents of abuse and one injury of unknown source documented to have occurred between January 2007 and September 2007. Continued review of the facility's incident reports and/or interview failed to show evidence that the administrator and the Department of Health were	W 149	1. The DoDS and QMRP will ensure that all staff are trained or re-trained on incident management and report incidents as required by facility policy.	11/2/07

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W 149	Continued From page 9 made aware of the five aforementioned incidents. Interview with the Resident Director (RD) and Qualified Mental Retardation Professional (QMRP) was conducted on September 25, 2007 at 3:21 PM and 3:44 PM respectively. They both indicated that staff who witnessed, discovered or were informed of the aforementioned incidents should have documented the incident on an incident report prior to end of his/her shift. The QMRP stated that the Department of Health (DOH) was to be notified of all allegations of abuse/neglect and injuries of unknown source immediately, followed by written notification within 24 hours. Review of the facility's "Incident Management" policy on September 26, 2007 revealed incidents were categorized into both reportable and serious reportable incidents. Allegations of abuse, neglect and injuries of unknown source were identified as serious reportable incidents. According to the policy, staff were required to "immediately call" the case manager, the DOH, and the client's parent or guardian for all serious reportable incidents. Incident report forms were to be completed on "all serious reportable incidents" and the incident report was to be forwarded to the DOH within 24 hours. However, the survey revealed that the facility had not consistently notified the State agency of the incidents, in accordance with its policies. 2. The facility failed to develop written policies regarding the notification of its administrator of all incidents for inclusion in its overall incident management policy. Cross-refer to W153. Review of the facility's	W 149	2. The Incident Management policy will be revised to ensure that the Administrator is notified of all incidents.	11/2/07

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W 149	Continued From page 10 incident reports, investigations and client records on September 25-27, 2007, revealed evidence of four incidents of abuse and one injury of unknown source. There was no documented evidence that the facility's administrator had been notified of these incidents. Review of the facility's "Incident Management" policy on September 26, 2007 revealed procedures for both verbal and written notifications of the client's case manager, the DOH, and the client's parent or guardian. The policy, however, failed to indicate that the administrator should be notified. It should be noted that further interview with the QMRP on September 28, 2007 revealed that the agency recently had changed the incident report form, to include a space designated for documenting the administrator. The new form, however, was not made available for review and had not been implemented for recent incidents (August or September 2007). 3. The facility failed to consistently document the notification of guardians and/or family members, as evidenced by the following: Interviews with the RD, QMRP and the Incident Management Coordinator indicated that facility policies state that the date and time that guardians and/or involved family members are notified of incidents, including those involving injuries to a client, should be documented on the incident report. This was verified through review of the policies. The survey, however, revealed that: a. According to an incident report dated March 28, 2007, Client #2 reportedly informed staff that he had fallen. A nurse examined him and found a	W 149	3. The DoDS will train the QMRP, RD and staff on the revised incident policy that includes notification to families/guardians and documentation of the notification.	11/2/07

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W 149	Continued From page 11 bruise on his lower back. Further review of the incident report failed to show evidence that the client's court-appointed guardian was notified. Interview with the guardian on October 1, 2007 confirmed that she was previously unaware of this injury. b. According to an incident report dated May 11, 2007, Client #2 reportedly sustained an abrasion to his head while disembarking from the facility van. First aid was applied. Further review of the incident report failed to show evidence that the client's court-appointed guardian was notified. Interview with the guardian on October 1, 2007 confirmed that she was previously unaware of this injury. c. According to an incident report dated August 20, 2007, Client #6 was taken to a hospital emergency room after he complained of stomach pain. He had been taken to an emergency room 8 days earlier for the same complaint. While the facility documented notification of the client's brother of the first incident, review of the August 20, 2007 incident report failed to show evidence that his brother was notified of the second trip to the hospital. On September 27, 2007, interview with the Residence Director (who had accompanied the client to the hospital) revealed that he could not recall whether the brother had been called after the second incident. 4. The facility failed to ensure consistent implementation of the "investigation" component of its Incident Management policies, as evidenced by the following: Cross-refer to W153 and W154. Review of incident reports, investigations and client records	W 149	4. The DoDS will ensure that the QMRP and the IMC are in-serviced on completing thorough and timely investigations of incidents per facility policy.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G094	A. BUILDING _____ B. WING _____	09/28/2007

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W 149	Continued From page 12 on September 25, 2007 and September 27, 2007, revealed two allegations of abuse and/or neglect (January 17, 2007 and April 8, 2007) and one allegation of verbal abuse (May 14, 2007). The QMRP was interviewed on September 25, 2007, at 3:44 PM. She stated that all allegations of abuse were to be investigated and completed within five business days. Review of the facility's "Incident Management" policy on September 26, 2007 verified this; "all investigations for serious reportable incidents will be completed within 5 business days ... " Survey findings, however, revealed no evidence that the January 17, 2007 and April 8, 2007 incidents were investigated; and, the investigation report for the May 14, 2007 allegation of abuse documented that it was submitted for review on May 24, 2007, and the Director of Operations signed it on May 25, 2007. 5. The facility failed to ensure implementation of its "Missing Person" policy, as evidenced by the following: Review of incident reports on September 25, 2007, beginning at 4:22 PM, revealed that on July 7, 2007, staff documented that Client #4 eloped while on vacation. According to the incident report, he walked away while staff were packing the van to return from Ocean City, Maryland. Further review of the report revealed that only the QMRP and the Department of Health (DOH) had been notified of the incident. When interviewed on September 27, 2007, the QMRP presented a copy of the facility's "Missing Persons" policy. Review of the policy revealed a section entitled, "Resident Returns to the Home." According to the policy, a nurse was to perform	W 149	5. The DoDS will in-service the Designated Nurse and RN Supervisor on the policy and documentation requirements. The DoDS will direct the IMC and QMRP to maintain fax receipts with incident reports that are faxed to DOH and DDS.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	09G094	A. BUILDING _____ B. WING _____	09/28/2007

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W 149	Continued From page 13 an examination of the individual and document the findings in the nursing log if emergency services were not warranted. Interview with the Designated Licensed Practical Nurse (LPN) on September 27, 2007 revealed that the nurse examined Client #4 when he returned; however, that information had not been documented. At the time of the survey, the facility failed to ensure its "Missing Persons" policy had been implemented as outlined. It should be noted that while the incident report indicated that the State agency was notified via facsimile (no date and no time specified), pre- and post-survey reviews of DOH's records failed to show evidence that the incident had been reported as alleged on the incident report. 6. On September 26, 2007, at 11:10 AM, interview with the QMRP revealed that Careco policies state that incident reports and investigative reports should be maintained in the facility, in a log book Designated "Incident Reports." Incident and investigation reports that were older than 12 months, "purged" from the current log book, also were to be kept in a closed file within the facility. On September 26, 2007, beginning at 9:43 AM, review of the Incident Report log book revealed a failure to implement that policy, as follows a. On September 25, 2007, a pre-survey review of incidents known to the State agency revealed that on April 3, 2007, Client #6 sustained a " medium burn " on his left forearm after an ironing board tipped over while a staff person was ironing. The iron reportedly hit the client's arm. There were no corresponding incident or	W 149	6. The DoDS will direct the QMRP and the IMC to maintain purged files in the home per policy. See response to #4 above.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 149	Continued From page 14 investigation reports available for review in the facility on September 26, 2007. Note: A copy of the April 3, 2007 incident report was delivered to the facility from the corporate office later that day, at approximately 4:20 PM. It should also be noted that there was no evidence that the April 3, 2007 incident had been further investigated, to ensure that facility policies had been followed. b. According to an Investigation Summary Report filed in the Incident report log book, Client #6 was taken to a hospital emergency room on August 20, 2007 after complaining of abdominal pain. There was no corresponding incident report available for review in the facility at that time. Note: A copy of the August 20, 2007 incident report was delivered to the facility from the corporate office later that day, at approximately 4:20 PM. c. On September 25, 2007, a pre-survey review of incidents known to the State agency revealed that on October 16, 2006, Client #2 sustained an injury to his head. The client reportedly bumped his head on a door frame while walking through the dining room. There were no corresponding incident or investigation reports available for review in the facility on September 26, 2007. It should be noted that there was no evidence that the October 16, 2006 incident had been further investigated, to ensure that facility policies had been followed.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of	W 153		

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	09G094	A. BUILDING _____ B. WING _____	09/28/2007

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W 153	Continued From page 15 mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all injuries of unknown source and allegations of abuse, were immediately reported to the administrator and to other officials in accordance with State law (DC regulation 22 DCMR Chapter 35, Section 3519.10), for three of the six clients residing in the facility. (Clients #1, #2 and #4) The findings include: 1. Review of the facility's incident reports and investigations on September 25, 2007 beginning at 4:22 PM revealed that the facility failed to provide evidence that the following incidents were immediately reported to the administrator and/or the Department of Health as required: a. On January 17, 2007 staff reported that Clients #1 and #4 were in a physical altercation that resulted in Client #1 needing emergency medical services to address an injury to his lower lip. Review of the emergency room consultation form dated January 17, 2007 revealed Client #1 received sutures to his lower lip laceration. b. On April 8, 2007, staff reported that Client #1 was verbally aggressive to his roommate Client #4. According to the incident report, Client #4 was kicked by Client #1 and then Client #4 bit Client #1 on the left side of his wrist.	W 153	1. See response to W122 and W149.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 153	Continued From page 16 c. On May 14, 2007, staff reported an allegation of verbal abuse towards Client #1. d. On July 7, 2007, staff reported that Client #4 eloped while staff were packing the van to return from the clients' vacation in Ocean City, Maryland. Interview with the Qualified Mental Retardation Professional (QMRP) was conducted on September 25, 2007 at 3:44 PM to ascertain information about the facility s incident management policy regarding injuries of unknown source, allegations of abuse/neglect and mistreatment. According to the QMRP, the Department of Health and the facility's administrator were to be notified immediately of all allegations of abuse/neglect, mistreatment and injuries of unknown source. However, at the time of the survey, the facility failed to provide evidence that the administrator and the Department of Health were notified of the reported aforementioned incidents. 2. Review of Client #2's medical records revealed one injury of unknown origin that was not reported in accordance with facility policies, as follows: Incident reports and investigations were reviewed on September 26 and 27, 2007. There was no incident report observed that indicated Client #2 had received x-rays after he was observed limping, for reasons not known. However, on September 28, 2007, at 2:18 PM, review of the client's podiatry records revealed that he had received an x-ray on September 12, 2007 to "rule out fracture of the great toe." The QMRP was	W 153	2. See response to #1 above.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 153	Continued From page 17 interviewed immediately, on site. The QMRP was unaware of the toe injury or that he had received x-rays. A moment later, interview with the Resident Director revealed that the client had been observed limping that morning. The nurse subsequently advised him to take the client to a podiatrist. It was the podiatrist who ordered the x-ray (results indicated "...thought to reflect an old fracture with some degree of posttraumatic degenerative disease." The Resident Director acknowledged that he had not completed an incident report, in accordance with facility policies. In addition, the State agency had not been notified and there was no evidence that the administrator had been notified of this incident. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse or neglect were thoroughly investigated, for two of the six clients residing in the facility. (Clients #1 and #4) The findings include: 1. The facility failed to ensure all allegations of neglect were investigated, as follows: Review of the facility's incident reports and investigations on September 25, 2007, beginning	W 154	1. See response to W149.	11/6/07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 154	Continued From page 18 at 4:22 PM, revealed that on July 7, 2007, staff reported that Client #4 eloped while staff were packing the van to return from the clients' vacation in Ocean City, Maryland. There was no evidence that the incident was investigated. The Qualified Mental Retardation Professional (QMRP) was interviewed on September 25, 2007. According to the QMRP, all allegations of neglect required an investigation. After further discussions, the QMRP agreed to determine whether the incident had been investigated. No investigation was provided for review before the survey ended on September 28, 2007. There was no evidence that the circumstances involved in the elopement had been investigated. 2. The facility failed to ensure a thorough investigation was conducted for all allegations of abuse, as follows: Review of the facility's incident reports and investigations on September 25, 2007, beginning at 4:22 PM, revealed that on April 8, 2007, staff reported that Client #1 was verbally aggressive to his roommate Client #4. According to the incident report, Client #1 kicked Client #4 and Client #4 bit Client #1 on the left side of his wrist. An "Incident Summary Report" had been completed for the aforementioned incident. Review of the summary, however, revealed that it documented only two components, a restatement of the actual incident and recommendations. There was no evidence that interviews or statements had been collected and reviewed to investigate the incident. Additionally, there was no documentation indicating whether the incident had been substantiated or unsubstantiated. At	W 154	2. The DoDS will review the elements and process of a thorough investigation with the IMC and the QMRP, and direct them to employ them in all future investigations.	11/2/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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W 154	Continued From page 19 the time of the survey, the facility failed to show evidence that the aforementioned incident had been thoroughly investigated.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator or designated representative within five working days of the incident, for one of the three clients in the sample. (Client #1) The findings include: On September 25, 2007, at 3:44 PM, interview with the Qualified Mental Retardation Professional(QMRP) revealed that all allegations of abuse were to be investigated and completed within five business days. However, review of incident reports on September 27, 2007 revealed two allegations that were not investigated within the prescribed time frame, as follows: 1. On May 14, 2007, there was an allegation made of verbal abuse towards Client #1. Review of the corresponding investigation report revealed that the findings were submitted for review on May 24, 2007. Further review of the investigation report revealed the Director of Operations signed the investigation on May 25, 2007. 2. There was an altercation between Clients #1	W 156	See responses to W122, W130, W149, W153 and W154.	11/2/07

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W 156	Continued From page 20 and #4 documented on April 8, 2007. Further review of the incident report revealed a corresponding incident summary report dated April 19, 2007. The incident summary report indicated that the QMRP was the investigator and only the QMRP ' s signature was present on the summary. At the time of the survey, the facility failed to show evidence that the administrator or designee had received the results of the aforementioned incident investigations within the required timeframe (five working days).	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure active treatment services were monitored, coordinated and integrated, for three of the six clients residing in the facility. (Clients #1, #3 and #4) The findings include: 1. Observation of Client #1 throughout the survey revealed the client smoked cigarettes. Review of the client's medical records on September 27, 2007 at 8:34 PM revealed a cardiology consultation report that documented recommendations including decreasing the client's use of tobacco to no more than three cigarettes a day.	W 159	1. The QMRP will consult with the psychologist and the primary care physician to develop a plan to assist the person to reduce his smoking for health reasons. The QMRP will consult with the person to decide on healthful substitutes for smoking. The QMRP will call a special meeting of the Human Rights Committee with the person present so that the HRC can determine whether the person's rights will be improperly restricted by the use of a smoking schedule or attempts to prevent the person from buying or borrowing cigarettes. The QMRP will act upon the recommendation of the HRC.	11/2/07

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FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 159	Continued From page 21 Interview was conducted with the designated Licensed Practical Nurse (LPN) on September 27, 2007, at 1:58 PM, to ascertain information regarding Client #1's smoking practices. According to the nurse, there was no schedule implemented to assist the client with reducing his tobacco intake. The nurse stated that the client was given $5.00 weekly that he used to purchase cigarettes. The nurse further indicated that the client maintained his own cigarettes. On September 26, 3007, at 7:37 AM, Client #1 was seen taking a cigarette outside to smoke. The Resident Direct (RD) was asked if Client #1 was on a schedule. He replied "He should have 4 cigarettes per day, per his physician's orders... 1 after breakfast, 1 after return from day program at 4:00 PM, 1 after his evening hygiene and he takes 1 to day program." The RD further indicated that the client was "really resourceful" and received cigarettes from peers outside of the facility (exact source not known). The client reportedly became upset when told to limit his smokes; he knew they were "his own personal property...he buys them... that makes them his." Interview was conducted with the QMRP on September 27, 2007, seeking further clarity about Client #1's smoking practices. The QMRP stated that no schedule had been implemented to assist Client #1 with a reduction on his tobacco intake. On September 28, 2007, at 6:20 PM, a follow-up interview with the RD indicated that he had sought input from Client #1's brother, in a telephone conversation just minutes earlier. The client and staff were "really struggling with the cigarette issue... he's on a set number of	W 159		

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 159	Continued From page 22 cigarettes a day... we need to do something with his doctor's orders and IHP... he has stolen from staff, pocket books... I know that he smokes at his day program too." At 7:11 PM, a direct support staff person approached the RD and asked about Client #3's cigarettes. The RD informed him that Client #3 was out of cigarettes and did not have money to purchase more. He told the staff that Client #1 was free to share some of his with Client #3 if he wanted, "but tell him that he'll run out faster with sharing with his smoke partner." When the staff asked where Client #1's cigarettes were kept, the RD pulled a pack out of his pocket and handed it to the staff, adding "they are now in his possession." At the time of the survey, the QMRP failed to facilitate an interdisciplinary team review of the client's smoking-related needs, to address the cardiologist's recommendation for a reduction in his tobacco intake. 2. The QMRP failed to establish a system to ensure clients had batteries available to operate their TV remote controls, as follows: On September 26, 2007, at approximately 8:40 AM, Client #2 openly declared that "my TV broke." The RD replied "you have lost your remote." This surveyor asked the client to show him the TV. Once in the bedroom, a direct support staff person presented a remote control. It was quickly determined that there were no batteries in the remote. Client #2 confirmed that this was his remote. He then demonstrated how he had been using his roommate's remote to change channels (both of their TVs responded to the same brand of remote control). The RD then informed the client that it was a matter of	W 159	2. The QMRP will provide IPPs to help the person learn how to budget his funds to purchase batteries as he needs them.	11/2/07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 159	Continued From page 23 "budgeting... you buy your own batteries." Review of Client #2's record on September 28, 2007 revealed no evidence that he received assistance with budgeting for such purchases. When interviewed later that day, the QMRP indicated that she was previously unaware that the client was out of batteries for his remote. She also acknowledged that there had been no budget developed to assist the client with planning for such purchases.	W 159		
	3. Cross-refer to W212. The QMRP failed to ensure comprehensive assessment of Clients #1 and #3's psychiatric conditions/ needs.		3. See response to W212.	11/2/07
	4. Cross-refer to W247. The QMRP failed to ensure that individual program plans and staff supports consistently encouraged client choice and self-management		4. See response to W247.	11/2/07
	5. Cross-refer to W252. The QMRP failed to ensure consistent data collection on Client #1's self-medication training program.		5. See response to W252.	11/2/07
	6. Cross-refer to W436. The QMRP failed to ensure that Clients #1 and #4 received training on the care of, and/or staff provide needed support to ensure that the clients wore dentures, as prescribed.		6. See response to W436.	11/2/07
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a comprehensive psychiatric	W 212	The QMRP will contact the psychiatrist and the Primary Care Physician to ensure both people receive a psychiatric assessment and that the PCP confirms their diagnoses.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G094	A. BUILDING _____ B. WING _____	09/28/2007

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W 212	Continued From page 24 assessment had been conducted for both of the two clients (out of three sampled clients) in the sample who were prescribed psychotropic medications for behavior management. (Clients #1 and #3) The finding includes: Interview with the Resident Director on September 25, 2007, at 2:33 PM, revealed that both Clients #1 and #3 received psychotropic medications to address maladaptive behaviors. This was verified through observation of the evening medication administration on September 25, 2007. Client #1's Annual Medical Evaluation, dated September 25, 2007, reflected a diagnosis of Intermittent Explosive Disorder (source and date of diagnosis not indicated). Interview with the Qualified Mental Retardation Professional (QMRP) and review of Clients #1's and #3's records on September 27, 2007 failed to provide evidence of a comprehensive psychiatric assessment that documented each client's Axis I diagnosis and justified the use of the prescribed psychotropic medications.	W 212		
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients received comprehensive vocational assessments as indicated, for one of the three clients in the sample. (Client #2) The findings include:	W 225	The DoDS will assist the QMRP to coordinate with day placement staff and the case manager to complete a comprehensive vocational assessment for the person.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 225	Continued From page 25 On September 27, 2007, at approximately 8:15 AM, the Resident Director (RD) stated that Client #2 performed volunteer work in the dining area of a nursing home. The RD indicated that he had just been informed by Client #2's job coach that the client had done so well during the "trial period" that the nursing home wanted him to continue there on a permanent basis. The job coach reportedly planned to inform the client's government case worker of his work performance and recommend that he remain at that location. Client #2 was observed at his day placement on September 27, 2007, beginning at 9:57 AM. The client placed eating utensils in individual plastic bags. He did so without any assistance from his job coach or his peers. His job coach stated that he and three other volunteers with disabilities placed the eating utensils, along with napkins and ice water, at the residents' place settings before lunch. The coach described the client as "one of my best workers." According to the coach, Client #2 had been volunteering there for approximately 1 month, "preparing him for employment." She stated that the client was "well-mannered and polite." The job coach indicated that Client #2's trial period was scheduled to end in 3 months (December), however, she would "try to get him to stay because he is very good." He and his peers did not earn a stipend or receive a wage for their work. They volunteered at this work site Monday-Friday, between 9:00 AM - 2:00 PM. At 10:16 AM, Client #2 approached the job coach and asked "I'm going to make more money, right?" After the client walked away, the coach	W 225		

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 225	Continued From page 26 acknowledged that money meant something to him. She said that while he was already motivated, she thought that he "would be even more motivated if he got a check in hand." At the time, there was only one paid staff in the dining area, the nursing home's dining room supervisor. This was verified a few minutes later through interview with the supervisor. She was the sole paid employee. She also confirmed that Client #2 "enjoys his work and is doing well." At approximately 10:30 AM, the coach indicated that to date, she had not met either the Qualified Mental Retardation Professional (QMRP) or RD; neither individual had visited the current setting. When asked about Client #2's strengths, the coach said she "he catches on very well... can perform most tasks after one demonstration... is independent in silver ware, wiping tables, pretty much everything." However, she described the client as distractible. When asked if he was currently employable, she responded "yes." Later that day, the RD and QMRP were asked about Client #2's day placement. At 5:24 PM, the RD confirmed that he had not observed the client performing work tasks at the current location. At approximately 5:29 PM, the QMRP also acknowledged that she had not visited the current work site. She did, however, report having received a telephone call from the job coach on the previous day. The coach reported that the client was "doing well." She confirmed that while the other clients were leaving the work site in December, they wanted "to keep him" at the nursing home and a case conference was planned for within the coming month (October) to discuss the proposal. When asked about a vocational assessment, the QMRP stated that	W 225		

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 225	Continued From page 27 she did not know whether an assessment had been performed. On September 28, 2007, beginning at 9:53 AM, review of Client #2's record failed to show evidence that he had received a comprehensive vocational assessment to determine his interests, skills and training needs. There was, however, an annual report (dated April 30, 2007) that was prepared by the client's current day program. The report indicated that while he was a "very hard worker," he required "verbal prompts throughout the day to remain on task." The day program plan for the coming year included a recommendation to "explore community based employment opportunities" by exposing the client to "at least 2 community-based employment opportunities per quarter." It should be noted that further interviews with Client #2 and residential staff confirmed that money was important to the client and that he enjoyed making purchases. According to the RD, the client was responsible for purchasing batteries for such items as his TV remote control. At the time of the survey, there was no evidence that Client #2's interdisciplinary team had a comprehensive vocational assessment, describing the client's current interests, strengths and needs, available for discussion at the upcoming case conference. It was proposed to keep the client placed in a volunteer position with no opportunity for advancement to a paid position of employment. It should be further noted that on September 28, 2007, at 4:51 PM, Client #2 enthusiastically declared to that he had received a paycheck that day. Payment was for "contract work" that he had	W 225		

PRINTED: 10/12/2007
FORM APPROVED
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W 225	Continued From page 28 performed during a recent period he spent working at a sheltered workshop, and not at the volunteer work site.	W 225		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in privacy skills in both formal and informal setting for two of the eight clients in the sample. (Client #4 and #5) The findings include: 1. On September 26, 2007, at 5:47 PM, Client #4 went upstairs to shower after he accidentally wet his pants. At the time, however, this surveyor was unaware of the toileting accident. Client #4 came out of his bedroom completely naked, walked approximately 8 feet across the hallway and into the bathroom. The client left the bathroom door open. When asked if he had a bathrobe, the client did not respond. When asked a second time, he held up his washcloth and then turned on the shower. The client's IPP failed to reflect a training program in privacy. 2. On September 28, 2008, at 5:31 PM, Client #5	W 242	1. The QMRP will provide new IPP's to educate everyone living in the home on privacy and the protection of personal dignity. 2. See response to #1 above.	11/2/07 11/2/07

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OMB NO. 0938-0391

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W 242	Continued From page 29 walked out of the bathroom on the main floor while drying his hands with a paper towel. At that same moment, Client #6 was observed with his pants down while seated on the toilet in the same bathroom. Both clients had been in the bathroom together. There were no staff in the immediate area at the time. The client's IPP failed to reflect a training program in privacy.	W 242		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client was provided opportunities for choice, encouraged and taught skills for self-management, for five of the six clients residing in the facility. (Clients #1, #2, #4, #5 and #6) The findings include: 1. The facility failed to ensure that each client was provided an opportunity to make choices regarding which sweetener to use, as follows: On September 26, 2007 at at 7:06 AM, a direct support staff person was observed pouring artificial sweetener (Sweet 'n Low or Equal) from pink or blue packets into bowls of cold cereal served for Clients #1, #2, #4, #5 and #6. A short while later, the same staff person was observed putting artificial sweetener into Client #1's hot coffee and #2's hot tea. At no time were the clients asked whether they preferred the blue or	W 247	1. The RD will ensure that a bowl or other container with both the "pink" and the "blue" sweeteners is placed on the table at meal or snack times. The RD will ensure staff are made aware that people can make their own selection from the bowl.	11/8/07

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W 247	Continued From page 30 the pink sweetener or wanted sugar instead. When asked, the staff person stated that no clients used regular sugar; it was not kept in the house. She further indicated that Clients #1, #3, and sometimes #6 drank coffee and #2 drank tea. On September 28, 2007, at 9:46 AM, the Designated Nurse was asked if any of the clients' physician's orders or prescribed diet plans required the use of artificial sweeteners. Aside from Client #3 having diabetes, she was unaware of any restrictions on Clients #1, #2, #4, #5 or #6 having regular sugar. A minute later, review of the menus posted in the kitchen revealed no evidence that clients, even those on reduced calorie diets, could not use regular sugar. The nurse also confirmed that Client #2 received Ensure pudding 3 times daily (as observed during the survey) to assist with maintaining his body weight (history of weight loss). On September 28, 2007, the Resident Director (RD) confirmed that they did not purchase sugar for use in the facility. Further interviews and record verification revealed no justification for facility staff failing to offer clients a choice in sweeteners. 2. The facility failed to develop a plan to assist Client #2 with meeting potential lady friends and/or maintain ongoing relationships, as follows: On September 26, 2007, at approximately 6:53 AM, Client #2 stated that he had a "girlfriend." He mentioned his "girlfriend [redacted]" a few more times during the survey. On September 28, 2007, Client #2's Individual Support Plan (ISP), dated April 30, 2007, was reviewed, beginning at 9:54 AM. There was one	W 247	2. The QMRP will coordinate with the Provider who is now serving "[redacted]" to determine whether she wants to maintain her relationship with the person, and ensure that her circle of support, including family and/or guardian do not object. If she so desires, and her family and circle of support agree, the QMRP will develop and implement a plan for the couple to maintain their contact. Regardless, the QMRP will develop a plan with the person's IDT to provide consistent opportunities for the person to meet potential friends and romantic partners, and to educated on and supported to make safe choices within accepted social norms.	11/2/07

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W 247	Continued From page 31 sentence in the ISP, stating he "enjoys dancing especially meeting women at the Chateau." However, review of the list of services and training objectives outlined for the coming year revealed no evidence that his interdisciplinary team had addressed his dating/ girlfriend/ sexuality needs. His records indicated that there was a sexuality therapist available on an "as needed basis," however, the client had not been to see her during the previous year (last documented visit was on January 27, 2006). A sexuality assessment, dated September 25, 2005, documented his attraction to members of the opposite sex and his interest maintaining telephone contact and visits with women he befriended. At 12:15 PM, interview with the RD indicated that Client #2 and Christine saw each other frequently. She lived in another facility operated by Careco. Reportedly, staff were bringing her to this facility to visit 2 or 3 times weekly and the RD had seen them holding hands on the porch. Facility staff reportedly drove Client #2 to her home approximately once a week. The client also reportedly bought her a gift while on vacation this past summer. At 2:34 PM, the Qualified Mental Retardation Professional (QMRP) indicated that she and the RD had engaged in past discussions regarding the possibility of Client #2 and Christine sharing time in a more private setting. The QMRP further indicated that she wanted the interdisciplinary team to discuss it. The QMRP immediately dismissed that idea by stating that she had since been told (she didn't indicate by whom) that Christine was leaving Careco therefore "this will no longer be necessary." No other discussions	W 247		

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W 247	Continued From page 32 had transpired regarding Client #2 meeting other women or the possibility of his maintaining a relationship with Christine after she moved from her current residence. It should be noted that during an October 1, 2007 telephone interview with Client #2's court-appointed guardian, she indicated that she was previously unaware of a girlfriend or the client's interest in meeting lady friends for dating and/or socializing.	W 247		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure program data was collected in the frequency required, for one of the three clients in the sample. (Client #1) The finding includes: Interview with the designated Licensed Practical Nurse (LPN) and review of Client #1 ' s records on September 27, 2007 revealed daily documentation was expected for the client's self medication program. According to the interview and review of Client #1's data collection record, the following information was being collected for the client's formal program objective that required him to complete the steps required to take his medications:	W 252	The DoDS will in-service the QMRP, Designated Nurse, RD, and direct care staff on the importance of accurate and timely data collection; the DoDS will in-service the QMRP on trending data and using it to craft IPPS supporting the person's skill acquisition and greater self-determination.	11/2/07

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W 252	Continued From page 33 - Resident gets cup of water. - Place medications in mouth. - Swallow medications with water. Review of the client ' s program monthly program documentation revealed the following gaps in data collection: September 2006 - No documentation for the 30th and no documentation for two days on the swallowing of medication task. November 2006 - No documentation for two days (23rd and 24th) February 2007 - No documentation on five days (3, 4, 14, 24, and 25) March 2007 - No documentation on two days (24 and 25) May 2007 - No documentation on two days (5 and 25) The facility failed to ensure consistent data collection for Client #1's self-medication training program. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06.	W 252		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263	See response to W124.	11/2/07

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W 263	Continued From page 34 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC) failed to ensure that restrictive programs were used only with written consents, for three of the three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. Cross-refer to W124.1. On September 25, 2007, at 2:33 PM, interview with the Resident Director revealed that Client #1 was prescribed psychotropic medications and utilized a Behavior Support Plan (BSP) to address maladaptive behaviors. Review of the BSP, dated September 18, 2007, revealed the plan incorporated the use of restrictive techniques to address the client's target behavior of physical aggression. Because the client lacked the capacity to make informed decisions, his brother was involved in his care. However, review of his records failed to show evidence of written consent from the brother. At the time of the survey, the facility failed to provide evidence that its Human Rights Committee (HRC) had obtained written informed consent for the use of Client #1's behavior support plan. 2. Cross-refer to W124.2.e. Client #2's records indicated that he was administered Ativan 2 mg prior to an MRI of the brain. The HRC failed to ensure written consent was obtained from the client's legal guardian, as follows: a. There was no evidence of written consent for the use of this sedative observed in the client's medical or habilitation records.	W 263	1. The HRC will more fully develop and document the process by which restrictive measures are reviewed and approved. The process will include HRC review of written informed consent for restrictive measures. 2. See response to W124. See response to #1 above.	11/2/07 11/2/07

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W 263	Continued From page 35 b. An October 1, 2007 telephone interview with the client's court-appointed guardian confirmed that she was previously unaware of the recommended MRI or the use of Ativan for sedation. c. While the handwritten telephone order, dated November 7, 2007, indicated that the HRC chairperson had given preliminary approval for the use of Ativan, review of the minutes taken at HRC meetings held October 26, 2006 and November 30, 2006 revealed no evidence that the committee as a whole had considered the matter. 3. Cross-refer to W124.3. On September 25, 2007, at 2:33 PM, interview with the Resident Director revealed that Client #3 was prescribed psychotropic medications and utilized a Behavior Support Plan (BSP) to address maladaptive behaviors. Review of the BSP, dated September 18, 2007, revealed the plan incorporated the use of restrictive techniques to address the client's target behavior of physical aggression. Because the client lacked the capacity to make informed decisions, his sister was involved in his care. However, review of his records failed to show evidence of written consent from the sister. The facility failed to provide evidence that its Human Rights Committee had obtained written informed consent for the use of Client #3's behavior support plan. 4. Review of HRC minutes for the 12 months preceding the survey failed to show evidence that the committee had advised the facility on how to ensure that written consent was documented in clients' records, prior to the use of restrictive strategies, including sedation prior to medical	W 263	3. See response to W124. See response to #1 above. 4. See response to W124. See response to #1 above.	11/2/07 11/2/07

PRINTED: 10/12/2007
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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 263	Continued From page 36 appointments.	W 263		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that prior to the implementation of more restrictive techniques, less intrusive techniques had been tried to address client behaviors, for one of the clients residing in the facility. (Client #4) The finding includes: Cross-refer to W153. Review of incident reports on September 25, 2007, beginning at 4:22 PM, revealed Clients #1 and #4 were involved in altercations on January 17, 2007 and April 8, 2007. Interview with the Resident Director on September 25, 2007, at 2:33 PM, revealed that both Clients #1 and #4 received psychotropic medications and had Behavior Support Plans (BSP) to address maladaptive behaviors. Review of Client #4 ' s records on September 27, 2007 revealed a BSP with an expiration date of September 18, 2007. The BSP addressed the target behavior of verbal aggression. The plan further documented that Client #4 received Risperdal 0.5 mg. Interview with the nurse on	W 278	The Director of Operations will contract with a different Psychologist to develop, monitor, and oversee behavior supports for people living in the home. The Psychologist and the QMRP will develop the process and manner of gathering and trending relevant data for use in recommendations on psychotropic medicine treatments.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 278	Continued From page 37 September 27, 2007 revealed that the medication had been discontinued in November 2006. The nurse further indicated that he had been placed back on psychotropic medications in July 2007 due to an increase in behaviors exhibited in June 2007. Further review Client #4 ' s record on September 27, 2007 revealed a Human Rights Committee meeting was held by telephone September 13, 2007. On that date, the HRC approved the use of Ativan 1 mg (three times daily) and Risperdal 1 mg (twice daily) to address the client ' s behaviors. Client #4 ' s record also documented monthly psychotropic medication reviews (PMR) for the period December 2006 through September 2007. The PMR forms did not reflect an increase in behaviors during the summer, as follows: December 2006 - 4 incidents of verbal aggression and 3 incidents of physical aggression. January 24, 2007 - 1 incident of verbal aggression and one incident of physical aggression. February 21, 2007 - No information on the targeted behavior documented. March 21, 2007 - No information on the targeted behavior documented. April 18, 2007 - No information on the targeted behavior documented. June 20, 2007 - 2 incidents of elopement were documented. Review of the behavior data sheets for the month of June 2007 revealed six incidents	W 278		

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 278	Continued From page 38 of non-compliance were documented. July 25, 2007 - No information was documented. The facility failed to document that less intrusive techniques were implemented to address Client #4 ' s behaviors, prior to the resumption of previously-discontinued psychotropic medications. It should be noted that interview with the QMRP on September 27, 2007 revealed that Client #4 ' s BSP had not been modified to reflect the discontinuance of Risperdal, or prior to the reintroduction of the psychotropic medication.	W 278		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, Interview and record review, the facility failed to ensure that medications were administered without error, for one of the six clients residing in the facility. (Client #6) The finding includes: The evening medication pass was observed on September 25, 2007. At 5:37 PM, the medication nurse stated that there was no Constulose laxative available in the facility to administer to Client #6. He stated that the client had been without Constulose for two days ("waiting for the pharmacy"). This was confirmed during the verification process that immediately followed the	W 369	The RN Supervisor will ensure that a physical count of drugs/medication occurs each month when a pharmacy delivery arrives. The RN Supervisor will report discrepancies in the delivery to the pharmacy and the DoDS in writing on the same day the discrepancy is noted. When a new medication is ordered and delivered outside of the normal schedule, the RN Supervisor will ensure the delivery is physically checked and counted, and that any discrepancy is reported to the pharmacy and the DoDS on the same day the discrepancy is noted.	11/2/07

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W 369	Continued From page 39 observed medication pass. According to the client's Medication Administration Record (MAR), a trained medication employee had documented "don't see" at 5:00 PM on September 23, 2007. The following evening, the regularly-scheduled medication nurse began documenting the Constulose was "on order." On September 25, 2007, at 6:45 PM, interview with the facility's Designated Nurse revealed that she had sought a refill; however, the pharmacy reportedly had declined to send more Constulose. Further interview revealed that the pharmacy previously had delivered a 1/2-quart bottle. On the next day, September 27, 2007, at 1:56 PM, the Designated Nurse presented a larger (1 quart) bottle of Constulose. The label indicated that it had been filled the previous day. It should be noted that Client #6 had a history of constipation. Facility staff took him to a hospital emergency room on August 12, 2007 after he complained of abdominal pain. On August 13, 2007, the primary care physician doubled the daily dose of Constulose, increasing it from 15 cc to 30 cc per day. The client was taken to the hospital emergency room on August 20, 2007 after further complaints of abdominal pain. Both times, emergency room clinicians detected stool in the colon; however, they had not determined the exact cause of the abdominal pain.	W 369		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

PRINTED: 10/12/2007
FORM APPROVED
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W 436	Continued From page 40 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients were taught to wear and/or care for their dentures, for two of the two (out of six) clients residing in the facility who were prescribed dentures. (Clients #1 and #4) The findings include: 1. Observation of Client #1 throughout the survey revealed the client was missing teeth in the lower front portion of his mouth. Interview with Client #1 on September 27, 2007, at 5:33 PM, revealed that he had dentures that he maintained in his bedroom. This was verified through interview with the Resident Director (RD) on the same day. Review of Client #1 ' s record on September 27, 2007, at 8:38 PM, further verified the client ' s statement by documenting a dental consultation was held on May 17, 2007. The consultation form indicated that the client had been given denture care instructions on that date. However, further interviews and record review revealed no evidence that Client #1 was being taught to wear his partial dentures. 2. On September 27, 2007, at approximately 3:15 PM, review of Client #4's medical chart for seizure-related documentation, revealed indications that the client used dentures. The client (who was not in the sample) had not been observed wearing dentures previously during the survey. Client #4 and his peers returned to the facility at 4:01 PM. He was not wearing dentures. When asked if he ha some, the client pointed to a	W 436	1. The QMRP will provide an IPP to teach the person proper care and use of his dentures. 2. See response above. The RD will ensure this person has supplies he needs to clean and wear his dentures.	11/2/07 11/2/07

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W 436	Continued From page 41 yellow denture cup that was placed on the top shelf of a cabinet in the dining room. The client opened the case, revealing upper and lower dentures that were partially submerged in water. The client stated that he did not know how to put them on; however, staff assisted him. A direct support staff who was working in the kitchen and dining room at the time overheard the conversation and confirmed that staff assisted him with cleaning and wearing his dentures. Further interview, however, revealed that Client #4 had not been wearing the dentures because he was without Polygrip denture adhesive. At approximately 4:12 PM, the Qualified Mental Retardation Professional (QMRP) was asked about the Polygrip. She thought the client had Polygrip. Instead, she thought he did not wear the dentures because of "discomfort." The QMRP acknowledged that the client did not have a training program for denture care and/or a program to assist Client #4 with becoming accustomed to wearing them. The QMRP left the room. She returned a few minutes later, stated that she had asked the RD about Polygrip and the RD had informed her that the client had been without Polygrip adhesive since Monday, September 24, 2007. The QMRP then revealed that she "didn't know that he had full upper and lower" dentures.	W 436		

PRINTED: 10/12/2007
FORM APPROVED

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I 000	INITIAL COMMENTS A licensure survey was conducted from September 25, 2007 through September 28, 2007. A random sample of three residents was selected from a resident population of six men with various degrees of disabilities. The findings of this survey were based on observations at the group home and two day programs, interviews with residents and staff and one resident's guardian, as well as the review of clinical and administrative records, including incident reports.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: On September 28, 2007, beginning at 6:08 PM, an environmental walk-through of the interior and exterior of the GHMRP revealed the following: Dining Room: 1. There was an accumulation of dust on the window curtains. 2. There was an accumulation of dust on the ceiling fan. Second Floor bathroom: 1. There were no curtains, blinds or shades in the window. An apartment building located a few properties over, in the back, was clearly visible when standing in the center of the room, or in front of the toilet. Presumably, persons in the apartment building could see residents taking	I 022	1. The curtains will be washed and re-hung. 2. The ceiling fan will be dusted. 1. The bathroom window will be covered with a curtain or a blind.	11/2/07 11/2/07 11/2/07

PRINTED: 10/12/2007
FORM APPROVED

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I 022	Continued From page 1 care of their personal needs, especially when the lights were turned on after dark. Residents used the upstairs bathroom for showering. At the time, the Resident Director acknowledged that the window was without a cover, to ensure the residents' privacy. Bedroom shared by Residents #1 and #4: 1. There was an accumulation of dust on the window curtains.	I 022	1. The bedroom window curtain will be washed and re-hung.	11/2/07
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, Interview and record review, the facility failed to ensure that all persons working with residents were trained to effectively meet the residents' dietary needs, for 4 of the 6 residents residing in the facility. (Clients #1, #3, #4 and #5) The findings include: 1. Dinner was observed in the facility on September 25, 2007 and breakfast was observed on September 26, 2007. At both meals, all six residents were served 2% milk. Residents #1, #3, #4 and #5 were all prescribed low cholesterol diets. In addition, Residents #1, #3 and #5 were prescribed reduced calorie (1800, 1800 and 1500, respectively) diets. On September 28, 2007, review of the menu revealed that residents who were prescribed low cholesterol and/or	I 042	1. The QMRP will ensure that the Nutritionist provides appropriate dietary management training to all facility staff.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 042	Continued From page 2 reduced calorie (1500, 1800) diets were to have skim milk. On September 26, 2007, review of staff in-service training records revealed no evidence of recent training on Nutrition, menus and/or prescribed diet plans. The most recent documented training had been provided on February 18, 2006 and only one of the employees who attended that session (19 months earlier) was still employed by the GHMRP. There was no evidence that the Residence Director, who was responsible for overseeing the purchase of menu items, had received training by the Nutritionist. 2. Resident #1's diet plan was changed on August 23, 2007, to reflect a restriction on daily fluid intake. As per orders from the nephrologist and primary care physician, his total fluid intake was not to exceed 1200 cc's daily. A newly-established schedule indicated that he should receive 6 oz with his afternoon snack, after return home from the day program. On September 26, 2007, at 4:21 PM, Resident #1 was observed drinking a 16.9 oz bottle of spring water with his snack. He finished the bottle in less than one hour. Subsequent review of staff in-service training revealed no documented evidence of applicable staff training. It should be noted that later that evening, at 6:16 PM, review of the resident's fluid intake chart revealed the Designated Nurse had documented 6 oz for the afternoon snack. When asked, she said the resident had been given 6 oz of juice. Subsequent interview revealed that neither the nurse, nor the Residence Director was previously aware that Resident #1 had taken a bottle of spring water. It remained unclear whether he drank the 16.9 oz of water and 6 oz of juice.	I 042	2. The QMRP will explain the need for fluid restriction to the person. The QMRP will ensure all staff are trained on the fluid restriction and how to support and monitor the person's intake.	11/2/07

PRINTED: 10/12/2007
FORM APPROVED

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CARECO 05	6934 9TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 071	Continued From page 3	I 071		
I 071	3503.2 BEDROOMS AND BATHROOMS Each bed shall be placed at least three feet (3 ft.) from any other bed and at least three feet (3 ft.) from any unprotected radiator. This Statute is not met as evidenced by: On September 26, 2007, at 8:00 AM, Resident #1's bed was observed placed only 22.5 inches away from Resident #4's bed. The beds remained in their same position on September 28, 2007, at 7:00 PM.	I 071	The DoDS and Director of Operations will review the physical setting and determine how to manage the space requirements properly.	11/2/07
I 073	3503.3(b) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (b) Clean comfortable pillow; This Statute is not met as evidenced by: On September 28, 2007, Residents #4 and #5 were observed to have flat bed pillows.	I 073	b. New pillows will be purchased.	11/2/07
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: A. On September 28, 2007, beginning at 6:08 PM, an environmental walk-through of the interior and exterior of the GHMRP revealed the following:	I 090		

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I 090	Continued From page 4 Back yard and porch: 1. There was an old car tire and hubcap, an ironing board, a fan and other items piled next to the trash cans in the back yard. The Resident Director indicated the car tire had been there since before he began working there in July 2007. The other items reportedly were destined for "bulk pick-up." 2. Both railings on the wooden steps leading from the back porch into the back yard were not secured. The railing on the right side (when descending from the porch) was extremely loose and wobbly to the extent that it might give way if an adult person were to apply their full body weight. The hand rail on the left had been reinforced with a board; however, it too wobbled when weight was applied. 3. Paint around the windows and window sills inside the back porch was peeling, chipped and dirty. It appeared that numerous coats of paint had been applied over the years and the resultant build-up was notably unattractive. 4. The paint on the inside and outside of the door leading from the porch to the back yard was peeling, chipped and dirty. The door appeared to be old, weathered and was notably unattractive. 5. A large gap (approx. 1/2 inch) was observed between the top of the back door and its frame. It appeared that the door was not properly centered within the frame, therefore the gap was increasingly large the further you went away from the hinges. A gap of approximately 1/4 inch was observed between the bottom of the outers door and its frame.	I 090	1. The trash will be removed from the exterior of the home. 2. The stair railings will be reinforced or replaced. 3. The maintenance department will scrape and repaint the window frames and sills. 4. The maintenance department will repair or replace the back porch door. 5. The door will be properly re-hung or it will be properly replaced to reduce or eliminate the gaps.	11/2/07 11/2/07 11/2/07 11/2/07 11/2/07

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FORM APPROVED

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I 090	Continued From page 5 6. There were significant gaps (approx. 1/4 inches) above and below the door between the porch and the kitchen. It should be noted that numerous mosquitos and other flying insects were observed in the GHMRP on each day of the survey. Kitchen: 1. There was food debris and other unknown substances in the residents' eating utensils storage tray in the drawer. 2. The handle on the upper left cabinet door above the stove was missing a screw and was not secured properly. 3. Cabinetry throughout the kitchen was notably unattractive, presumably due to age and wear. Basement: 1. Two of the 3 ceiling light fixtures in the back area of the basement (where the storage shelves and laundry appliances were located) were without bulbs. The Residence Director indicated that those 2 electrical sockets were inoperable. 2. There were several piles of musty and mildewed indoor/outdoor floor covering (carpet?) on the floor beneath some storage shelves in the back area. 3. One ceiling tile (approx. 2 ft. x 4 ft. dimension) was bowed downwards and discolored with black and orange mold and mold stains. 4. There was a strip of molding (approx. 3 ft. in length) missing at the base of the wall in the front	I 090	6. The kitchen door will be properly re-hung or properly replaced to reduce or eliminate gaps. 1. The utensil tray will be cleaned. 2. The cabinet door handle will be repaired or replaced. 3. The cabinetry will be cleaned and the DoDS will request that the cabinets be replaced. 1. Inoperable light fixtures will be repaired or removed/capped. 2. Old carpet remnants will be removed. 3. The ceiling tile will be replaced. 4. The molding strip will be replaced.	11/2/07 11/2/07 11/2/07 11/2/07 11/2/07 11/2/07 11/2/07 11/2/07

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	09G094	A. BUILDING _____ B. WING _____	09/28/2007

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I 090	Continued From page 6 right corner. 5. Approximately 8 sq. ft. of carpeting in the front right corner had yellow, black and/or brown stains. First floor hall area: 1. There were at least 2 weak spots in the floor boards at the base of the staircase; they 'gave' when stepped upon. Dining room: 1. There was a significant accumulation of dust on the curtains hanging in the windows. Living room: 1. There were 3 burn marks in the carpet that by their shape, appeared to have been caused by an iron. Resident bedrooms. 1. There was an air conditioning unit in the window above Resident #3's bed. The wooden boards that were used to secure the a/c unit were in various states of disrepair. Some boards had 'contact paper' on them; the contact paper was peeling in some areas. Other boards were exposed wood. The overall appearance was unkept and unattractive. 2. Both Resident #2 and Resident #3 had loose dresser drawers, filled with personal clothing items, that were placed directly on the floor underneath their beds. Each resident had a bed, nightstand and wardrobe; the 2 drawers placed on the floor were their only dresser drawers	I 090	5. Stained carpet will be removed if it cannot be properly cleaned. 1. The floor boards will be checked and repaired/replaced. 1. Curtains will be washed and re-hung. 1. Damaged carpet will be replaced. 1. The seating of the air conditioner will be reviewed and repaired in the most attractive way possible. 2. The drawers will be replaced with under-bed clothing storage containers.	11/2/07 11/2/07 11/2/07 11/2/07 11/2/07 11/2/07

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I 090	Continued From page 7 3. There was a significant accumulation of dust in the bedroom shared by Residents #1 and #4, especially on the carpet in the corners, along the molding/ walls and on their window curtains. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06. 4. There was a burn mark in the carpet just inside the door to the bedroom shared by Residents #1 and #4. Judging by its shape, the burn appeared to have been caused by an iron. 5. The pillow cases on Resident #2's and Resident #5's bed pillows were soiled. 6. The personal toiletry kits for each of the 6 residents were soiled with dirt and/or globs of old toothpaste. The Resident Director indicated that the residents received staff assistance in maintaining their kits. B. On September 25, 2007, at 2:23 PM, there was a long tear observed in the carpet on the front porch, where the carpet turned downward, leading from the porch onto the first step down (towards the front walk). There was a throw/ foot rug placed on the porch at the top of the front steps and another throw/ foot rug placed on the porch immediately in front of the main entrance. Corners of those 2 foot rugs were curled upwards. The upturned corners and the tear in the carpeting presented potential trip hazards. At 5:08 PM, further inspection of the front porch revealed numerous wooden floor boards that were in various states of decay; they sagged downwards when stepped on. The Resident Director acknowledged that the front porch was in a state of disrepair. He immediately removed the	I 090	3. The room will be thoroughly dusted. The RD will ensure that dusting is completed throughout the home on a regular basis. 4. Damaged carpet will be replaced. 5. New pillows will be purchased. 6. The personal care kits will be cleaned. The RD will ensure that kits are checked and cleaned thoroughly at least weekly. B. The porch will be repaired for safety and improved appearance.	11/2/07 11/2/07 11/2/07 11/2/07 11/2/07

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I 090	Continued From page 8 curled foot rugs, secured the carpet edges and taped the long tear at the top of the steps. He indicated that management had met during the previous week to discuss needed porch renovations. On September 26, 2007, management forwarded a copy of a newly-signed work order, thus verifying that porch repairs were scheduled to begin the next weekend. Preliminary repairs began on September 28, 2007, when access to portions of the porch was closed off with yellow tape.	I 090		
I 100	3504.10(b) HOUSEKEEPING Each GHMRP shall provide clean linens as follows to each resident at least weekly: (b) One (1) pillowcase; This Statute is not met as evidenced by: On September 28, 2007, beginning at 6:08 PM, an environmental walk-through of the interior and exterior of the GHMRP revealed that pillow cases on Resident #4's and #5's pillows were soiled.	I 100	The RD will ensure each person has clean linens at least weekly.	11/2/07
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: 1. On September 26, 2007, at approximately 7:58 AM, Resident #1 was asked why he was wearing a pair of dress socks while he wore casual shorts and sneakers. He complained that his athletic socks all had holes in them. During the next half hour, the Resident Director,	I 108	1. The RD will check the person's entire clothing inventory and discard damaged items, then replace them. The RD will ensure the person has adequate supplies of clothing in good condition.	11/2/07

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I 108	Continued From page 9 Resident #1 and this surveyor examined the resident's clothing inventory. Ten of the resident's 12 athletic socks had holes in them. (Note: The 2 drawers contained dozens of undershirts and briefs with holes in them and the drawers were in general disarray.) There were 2 socks without holes found in the drawers that morning. Resident #1 put them on before leaving for day program. 2. On September 28, 2007, at approximately 7:00 PM, inspection of Resident #6's clothing inventory revealed 1 pair of white athletic socks and no dress socks. 3. On September 28, 2007, at approximately 7:05 PM, Resident #5's dresser drawers contained 1 pair of underbriefs. On September 28, 2007, at approximately 7:07 PM, the Resident Director acknowledged that the residents did not have at least 7 pairs of socks appropriate to his daily activities.	I 108	2. See response to #1. 3. See response to #1.	11/2/07 11/2/07
I 109	3504.16 HOUSEKEEPING Each GHMRP shall label inconspicuously each item of clothing as belonging to a particular resident as indicated in his or her Individual Habilitation Plan (IHP). This Statute is not met as evidenced by: 1. On September 26, 2007, at approximately 7:52 AM, Resident #1 opened the drawers holding his socks, underbriefs and undershirts. Among the clothing items observed were 6 pairs of underbriefs that were not labeled with resident initials.	I 109	1. The RD will ensure that all of each person's clothing is properly labeled, and that each person has only his own clothing in his drawers.	11/2/07

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I 109	Continued From page 10 It should be noted that 2 other pairs of underbriefs and 4 undershirts in his drawers were marked with other residents' initials. 2. On September 28, 2007, at approximately 7:05 PM, Resident #5's dresser drawers contained numerous pairs of white athletic socks that were not labeled with resident initials.	I 109	2. See response to #1 above.	11/2/07
I 110	3504.17 HOUSEKEEPING Each GHMRP shall ensure that each resident ' s clothing is kept in good condition, laundered, and cleaned. This Statute is not met as evidenced by: On September 26, 2007, inspection of Resident #1's clothing inventory revealed the following: - 10 out of 12 white athletic socks had holes in them; - 8 undershirts with holes in them; - 10 pairs of underbriefs with holes in them; and, - 3 "Special Olympics" T-shirts with holes and frayed/ worn neck lines.	I 110	See response to I 109	11/2/07
I 111	3504.18 HOUSEKEEPING Each GHMRP shall establish sorting and washing procedures to ensure adequate sanitation either by assisting the residents to perform these tasks or by performing the tasks for the residents as indicated in the their Individual Habilitation Plan (IHP).	I 111		

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I 111	Continued From page 11 This Statute is not met as evidenced by: 1. On September 26, 2007, at approximately 8:00 AM, inspection of Resident #1's clothing supply revealed 2 pairs of underbriefs and 4 undershirts in his drawers that were marked with either Resident #3's or Resident #4' initials. 2. On September 28, 2007, at approximately 7:00 PM, Resident #6's top dresser drawer contained a pair of underbriefs that was labeled with Resident #4's initials and an undershirt marked with Resident #5's initials. 3. On September 28, 2007, at approximately 7:05 PM, Resident #5's dresser drawers contained numerous pairs of of white athletic socks that were not labeled with resident initials. By contrast, his roommate's (Resident #6) drawers only contained 1 pair of white socks. When asked, the Resident Director was unsure whether the two men might have been sharing the same sock supply. 4. On September 26, 2007, at approximately 4:20 PM, Resident #1 was observed wearing one of Resident #3's athletic shirts. When the Resident Director asked him why he was wearing his house mate's shirt, he replied that he had borrowed it. When asked if the other resident knew that he had lent the shirt to him, Resident #1 laughed. There was no evidence of a system whereby staff routinely and effectively assisted the residents with laundry and sorting procedures that assured hygienic and sanitary practices.	I 111	1. See response to I 109 2. See response to I 109 3. See response to I 109 4. The RD will ensure that staff support each person to wash and store his own belongings in his own areas.	11/2/07 11/2/07 11/2/07 11/2/07
I 187	3508.5(d) ADMINISTRATIVE SUPPORT	I 187		

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I 187	Continued From page 12 Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: The Organizational Chart (dated September 2007) that was made available for review on September 27, 2007, at 2:49 PM, did not reflect the current lines of authority within the nursing department, to include the recently-hired RN Supervisor.	I 187	The organization chart will be updated.	11/2/07
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on September 27, 2007, at 7:21 PM, revealed the GHMRP failed to provide evidence that one direct support staff member and two nurses had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter.	I 203	The QMRP and RD will schedule each staff person's annual employment review. The RN Supervisor will schedule each nurse's annual review.	11/2/07
I 206	3509.6 PERSONNEL POLICIES	I 206		

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I 206	Continued From page 13 Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on September 27, 2007 revealed the GHMRP failed to provide evidence that current health certificates were on file for one nurse and four consultants. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06.	I 206	The Human Resources Department will acquire the health certificates and place copies in the file at the home.	11/2/07
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: On September 26, 2007, beginning at 3:24 PM,	I 223	The QMRP will provide copies of the standard agendas that were used for the trainings.	11/2/07

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I 223	Continued From page 14 review of the GHMRP's staff in-service training records revealed that there were no agendas available for training sessions that were indicated by staff signature sheets. For example, there were no agendas or handouts to indicate the subject matter discussed at the following: - September 6, 2007 "Fire Safety, Cooking Safety, Electrical Safety;" - July 23, 2007 and August 11, 2007 "Sexuality;" - August 8, 2007 "ISPs/Active Treatment;" - July 19, 2007 "Rights of Persons with MR/DD Most Integrated Setting;" - August 8, 12 and 13, 2007 "Role of The Professional Counselor;" and other recent training on such topics as "Ethics in The Workplace," "Securing Medical and Dental Care" and "Sign Language." For the most part, the only agendas available for review were those that were brought by DDS personnel when they presented training on DDS policies.	I 223		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that all staff, including nurses, had current certification in	I 227	The Human Resources Department will ensure that each nurse has a current CPR certificate on file in the home.	11/2/07

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I 227	Continued From page 15 Cardiopulmonary Resuscitation (CPR). The finding includes: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on September 27, 2007, at 7:21 PM, revealed the GHMRP failed to provide evidence of current CPR certification for one nurse.	I 227		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: 1. Cross-refer to I042. Observation of dinner served on September 25, 2007 and breakfast served on September 26, 2007 revealed that residents' dietary orders were not followed. Residents #1, #3, #4, #5 and #6 were all prescribed specialized diets, for which they were to have skim milk at meals. Staff served 2% milk to all six residents. In addition, Resident #1 drank at least 16.9 oz of spring water with his afternoon snack on September 26, 2007. His prescribed fluid restriction, however, limited him to just 6 oz at snack time. It should be noted that interviews with the nurse and other staff revealed the possibility that in addition to the 16.9 oz of water, the resident may also have drank 6 oz juice that same afternoon.	I 229	1. The QMRP will engage the nutritionist to provide dietary training to people served and staff.	11/2/07

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I 229	Continued From page 16 The most recent documented training by the Nutritionist had been provided on February 18, 2006. Only one of the employees who attended that session (19 months earlier) was still employed by the GHMRP. 2. Resident #4 (who was not in the sample), had a diagnosis of seizure disorder. Review of the staff in-service training records revealed that the most recent documented training on seizures had been provided on January 30, 2006 (20 months earlier).	I 229	2. The RN Supervisor will provide seizure training to the staff.	11/2/07
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of signed agreements or contracts with each the consultants that provided professional services. The finding includes: Interview with the Qualified Mental Retardation Professional and review of personnel records on September 27, 2007 revealed the GHMRP failed to have a contract or written agreement on file for three consultants.	I 274	The Human Resources Department will ensure signed contracts for all consultants are on file in the home.	11/2/07
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5,	I 379	See response to Federal Deficiencies W122, W149, W153, W154, and W156.	11/2/07

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I 379	Continued From page 17 each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that the Department of Health, Health Regulation Administration, was notified of incidents or events that substantially interfered with a resident ' s health, welfare, living arrangements, well being or in any other way placed the individual at risk, immediately by phone then followed up by written notification, for two of the six residents of the facility. (Residents #1 and #4) The findings include: Review of incident reports and investigations on September 25, 2007, beginning at 4:22 PM, revealed the GHMRP failed to provide evidence that the following incidents had been reported to the Department of Health: a. On January 17, 2007, staff reported that Resident #1 and #4 were in a physical altercation that resulted in Resident #1 needing emergency medical services to address an injury to his lower lip (laceration). b. On April 10, 2007, staff reported that Resident #1 needed to be picked up from the day program due to knee pain. The resident was subsequently seen at the emergency room and diagnosed with a knee sprain c. On April 18, 2007, staff reported that Resident	I 379		

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FORM APPROVED

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 05	6934 9TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 18 #1 was verbally aggressive to his roommate Resident #4. According to the incident report, Resident #1 kicked Resident #4 who in turn, bit Resident #1 on the left side of his wrist. d. On July 7, 2007, staff reported that Resident #4 eloped while staff were packing the van to return from the resident ' s vacation in Ocean City, Maryland. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06.	I 379		
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Nursing staff failed to consistently implement the GHMRP's policies on maintaining Medication Administration Record (MARs), as follows: The evening medication pass was observed on September 25, 2007. At 5:38 PM, Resident #5 was given his medications. The nurse stated that the pharmacy had not delivered a new supply of Constulose (prescribed to address Resident #5's history of constipation) and the resident, therefore had been without Constulose for 2 days. At approximately 6:30 PM, review of the resident's MAR revealed the following: * September 23, 2007, 5 PM - A trained medication employee (TME) circled her initials and documented "don't see" on the back of the MAR sheet. * September 24, 2007, 7 AM - A nurse initialed the MAR, documenting having administered the Constulose as ordered.	I 474	See response to Federal Deficiency W369. The nursing policy will be revised to include instructions on proper documentation when medications are not administered as ordered.	11/2/07

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I 474	Continued From page 19 * September 24, 2007, 5 PM - A nurse circled her initials and documented "on order"on the back of the MAR sheet. * September 25, 2007, 7 AM - A nurse left the space blank, with no other documentation evidenced. At 6:45 PM, interview with the Designated Nurse confirmed that the resident's supply of Constulose had run out on September 23, 2007. She could not, therefore explain why a nurse had documented administering it the next morning. While looking at the MAR, the Designated Nurse also acknowledged that the morning nurse had failed to document the MAR properly earlier that day. On the next day (September 26, 2007), at 9:05 AM, review of Resident #5's MAR revealed that the morning nurse had changed/ amended the entry from the preceding day; she initialed the space for September 25, 2007 at 7 AM, circled her initials and then documented on the back that the Constulose was on order. The nurse had not, however, documented that this was a late entry. The GHMRP's policies on "Medication Administration" dated 2007 were reviewed on September 28, 2007, beginning at approximately 10:15 AM. The policy included the following: "After the medication is taken, the nurse records it in the individual's MAR... The licensed nurse initials the MAR to indicate that medication has been administered or that she/he has observed the individual self-administering..." It should be noted that further review of the 2007 "Medication Administration" policy revealed that it	I 474		

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I 474	Continued From page 20 did not include instructions on proper documentation when medications are not administered as ordered (for whatever reason), in accordance with standard nursing practices.	I 474		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: 1. Cross-refer to Federal Deficiency Report - Citation W124 Interviews and record review revealed that the facility had not established and implemented a system to inform Resident #2's court-appointed guardian of changes in his medical condition and/or recommended treatments, or otherwise ensured the guardian's participation in the decision-making process. 2. Cross-refer to Federal Deficiency Report - Citation W130 The facility failed to ensure privacy during personal care, for six of the six residents residing in the facility, as evidenced by the folllowing: a. Resident #4 was observed walking naked through the upstairs hallway, without staff assistance/ guidance to protect his privacy. b. Resident #5 was observed leaving a restroom while Resident #6 was seated on the toilet with his pants down in the same restroom. There were no staff in the immediate area at the time.	I 500	1. See response to Federal Deficiency W124. 2. See response to Federal Deficiency W130	11/2/07 11/2/07

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I 500	Continued From page 21 c. There were no blinds or curtains in the window of the upstairs restroom. An apartment building located a few properties over, in the back, was clearly visible when standing in the center of the room, or in front of the toilet. Presumably, persons in the apartment building could see residents taking care of their personal needs, especially when the lights were turned on after dark. Residents used the upstairs bathroom for showering. 3. Cross-refer to Federal Deficiency Report - Citation W436 The facility failed to ensure that the two residents who were prescribed dentures were taught to wear and/or care for their dentures.	I 500	3. See response to Federal Deficiency W436.	11/2/07

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R 000	INITIAL COMMENTS A licensure survey was conducted from September 25, 2007 through September 28, 2007. A random sample of three residents was selected from a resident population of six men with various degrees of disabilities. The findings of this survey were based on observations at the group home and two day programs, interviews with residents and staff and one resident's guardian, as well as the review of clinical and administrative records, including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the personnel records on September 27, 2007, at 7:21 PM, revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the	R 125	The Human Resources Department will provide background checks for staff per regulation.	11/2/07

Health Regulation Administration

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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R 125	Continued From page 1 jurisdictions where the employee resided and worked for two direct care staff. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06.	R 125		